on early exposure to the real world of problem-centred care, fiscal restraint and limited resources as well as to the presence of pharmaceutical companies with their own goals. Responsibility for ethical behaviour lies with the individual. I took the oath of Geneva (World Health Organization), not a promise to abide by Guyatt's guidelines.

Universities' funding of research has depended heavily on faculty clinical earnings, a situation in which clinicians support not only themselves but the pure researchers as well. Is this really any different from the pharmaceutical companies' funding education and research, ultimately benefiting their other corporate goals?

Both medicine and the pharmaceutical industry would benefit by collaboration, teamwork and funding within common guidelines or a framework of ethical behaviour. Surely Guyatt does not have a monopoly on virtue? Perhaps his administrator or CME director had an equally valid viewpoint?

Those who see themselves only as pawns of multinational corporations, who are intolerant of other points of view and who would sell themselves for 30 pieces of silver are all poor role models for the "real world."

Richard G. Stopps, MD, FRCSC
Hamilton, Ont.

I think it is regrettable that Dr. Guyatt chose confrontation in dealing with a situation he finds personally morally unacceptable.

How much more productive it might have been to develop a program that would teach his charges how to interact ethically with industry representatives. As things stand, these physicians will go out into private practice not only ill-prepared but prejudiced — an opportunity lost and a pity.

F. William Danby, MD
Chair, Division of Dermatology
Queen's University
Kingston, Ont.

[The author responds:]

Dr. Greenwald and the junior physicians with whom he spoke appear not to have read the article "Development of residency program guidelines for interaction with the pharmaceutical industry" (*Can Med Assoc J* 1993; 149: 405–408), by our Education Council, which described the development of the guidelines. If they had, they would not characterize our approach as patronizing. The process of guideline development began with spirited debate among the residents. They endorsed the guidelines as something they wanted for their program before the faculty committee's debate began. Greenwald's letter is filled with resentment toward academic medicine and ends with a note of disrespect toward young physicians, whom he describes as unable to communicate with their patients about drugs. Both attitudes are unfortunate.

Most of Dr. Stopps' letter concerns an issue addressed by neither the original article nor the cautionary tale — namely, industry funding of research. Our guidelines for interaction with the industry did, however, define the circumstances in which industry funding for educational activities is acceptable. Parallel guidelines for research settings could minimize the conflict of interest that researchers sometimes face when receiving industry funding.

All three letters raise questions of what ethical approaches we should inculcate in our young physicians. In the editorial that accompanied our initial article ("Addressing the pharmaceutical industry's influence on professional behaviour" [*Can Med Assoc J* 1993; 149: 403–404]) Dr. Robert F. Woollard described a "three-step dance" we tend to do with ourselves. The first step is to refuse to state the obvious: that the primary goal of the pharmaceutical industry is to make a profit. The next step is to deny that industry gift-giving is meant to influence physician behaviour to the benefit of the industry. The final step is to deny that such influence is successful. In plain terms, industry gift-giving is bribery and is often successful. Our guidelines suggest that we should encourage our physicians-in-training not to accept bribes and that we should not allow our residency programs to be a party to bribery. This approach seems to strike Greenwald, Stopps and Danby as one that either does not teach our residents how to interact ethically with industry representatives or is unrealistic for real-world physicians. I believe they are underestimating their junior colleagues' potential for living without industry handouts.

Finally, the three letters assume that physicians must rely on biased information from the industry to guide their prescribing.[1] Alternative sources include academic journals, respected colleagues, the *Medical Letter* and increasingly sophisticated computerized information sources. Our experience is that physicians-in-training and community doctors can draw their information from these sources and provide optimal care while so doing.

Gordon Guyatt, MD, MSc, FRCPC
Professor of medicine and of clinical epidemiology and biostatistics
McMaster University
Hamilton, Ont.

Reference

1. Wilkes MS, Doblin BH, Shapiro MF: Pharmaceutical advertisements in leading medical journals: experts' assessments. *Ann Intern Med* 1992; 116: 912–919

Involving surgeons in discussions of breast cancer surgery

It is unfortunate that none of the authors of "Variation in breast cancer surgery in Ontario" (*Can Med Assoc J* 1994; 150: 345–352) is a surgeon.

It is immediately obvious that there are two major factors to consider in a discussion of variations from one region to another in rates of

breast-conserving surgery: the surgeon's advice and the patient's consent. All decisions about surgical treatment are the result of interaction between an individual surgeon and an individual patient. There are other interested parties, such as house staff, patients' families and other health care professionals who may play a role, but it is largely the patient who gives consent to have a particular procedure performed by a particular surgeon.

There is an unstated assumption in Dr. Neill A. Iscoe and colleagues' article that higher rates of breast-conserving therapy correlate with medical care that is up to date. I believe that a careful analysis of this assumption is in order. Given that the 5-year and 8-year survival rates are virtually identical for several modalities of treatment of breast cancer, consideration of one form of therapy as superior to another suggests that some other factors are present.

Whether these factors are economic, psychosocial or even political is unknown; thus, the results of the current study are significant only in a statistical sense. Although it is interesting to note that there are significant variations in therapeutic choices from one geographic region to another, I am somewhat alarmed that this kind of information is used as a "marker" in evaluating hospitals. Aside from the fact that hospitals have no policies regarding this kind of therapeutic decision-making, it appears impossible to determine from the present study exactly what is being measured (perhaps "political correctness"?).

May I suggest that the most important factor in shaping the surgeon's point of view is the locale in which his or her residency training was completed. Philosophies adopted during residency training programs influence the nature of one's surgical practice for decades. A dramatic example might be a surgeon who has trained in a setting in which the psychosocial impact of breast surgery is considered insignificant; at the other extreme would be a graduate of a training program in a large Canadian city, for whom issues of psychosocial adjustment, body image and feminist ideology assume profound significance. Such philosophic variables would certainly influence attitudes toward conservative surgery. The present geographic location of the surgeon's practice would have a relatively minor influence.

From the rural patient's perspective, the main argument against breast-conserving surgery is the prospect of spending 5 consecutive weeks 200 km or more from home and undergoing daily "high-tech" treatments in the relatively impersonal (and sometimes expensive) world of tertiary care in a major urban centre.

I would plead for breast surgeons to be involved in discussions of breast surgery. It is obviously beyond the authors of this study to appreciate the complexity of the scientific issues involved, not to mention the cultural, psychosocial and political elements.

Randy W. Friesen, MD, FRCSC
Prince Albert, Sask.

[Three of the authors respond:]

Dr. Friesen's letter sheds little light on the issues surrounding regional variability in the use of breast-conserving surgery.

Friesen indicates that the selection of a surgical procedure is a decision reached by the patient after receiving advice from her surgeon. The implication is that patient consent legitimizes variability. This is an unsupported assumption. Every practitioner (including the first author — an oncologist with a primary interest in malignant melanoma and other solid tumours) has faced the challenges of communicating difficult news and complex information to patients and then attempting to elicit their treatment preferences. The inadvertent miscommunication that occurs in doctor–patient encounters is well known.

Friesen opines that the surgeon's point of view is most closely related to the locale of training. Data were not available to test that hypothesis or to test the more plausible hypothesis that date of training was influential. Friesen specifically implies that training programs vary in the emphasis they place on the impact of mastectomy on body image and psychosocial adjustment postoperatively. We would be very curious, as doubtless would the profession and the public, to hear about any Canadian program that teaches that "the psychosocial impact of breast surgery is considered insignificant."

Having claimed that the current locale of the surgeon's practice would likely be of minor significance, Friesen immediately goes on to note that a major consideration in procedure selection from a patient's viewpoint might well be the distance to treatment centres.

We agree with Friesen that many factors influence procedure selection for a woman whose breast cancer has just been diagnosed. Leaving aside the rare occurrence of major coding errors by hospitals, the extent of variability observed implies that these other factors are distributed unevenly by hospital and region. Thus, we do not agree that the results are significant in only a statistical sense.

Friesen is concerned that this kind of information might be used as a "marker" for evaluating hospitals and, indirectly, the staff in them. Our report and others like it do not provide information about the quality of care in any particular region. What reports like ours do provide are signposts for local follow-up.

Like Friesen, we believe that the decision regarding a breast surgery procedure is one made by the patient in consultation with her surgeon. As we pointed out in our article, a variety of systemic factors, ranging from access to screening and early diagnosis to availability of radiotherapy facilities, can shape the decisions to be made. So will the surgeon's own beliefs and communication style. The impact of these diverse factors can

For prescribing information see page 877 →